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EDITORIAL

THE CORRECT PLACE OF THE LOUISIANA LEPER HOME.

In furthering the transfer of the Louisiana Leper Home to the U. S. Federal Government, Governor Parker, we hope unwittingly, has slurred the historical record of the Home, and the impression he may have created needs to be obliterated. In saying that under Federal control "these poor unfortunates would be handled along the line of most modern and scientific methods," Governor Parker has overlooked more than twenty-five years of service in this State.

The Louisiana Leper Home was established in 1894.

It was the first institution devoted to the care and treatment of leprosy in the United States.

It was the first institution in the United States to establish the cure of leprosy.

It determined the use of Chaulmoogra oil in its crudest liquid form as *the* treatment of the disease. As long ago as 1896, the

essential oil of Chaulmooga was essayed in treating lepers. This is important as bearing on the recent reports on the use of "ethyl ester" which has been derived from this essential oil and which now seems efficacious in treating leprosy.

When the U. S. P. H. S. established its colonization of lepers in the Philippines, the methods of the Louisiana Leper Home were studied and employed.

The work of the Louisiana Leper Home has had world wide acceptance as being modern and progressive. No evidence before the Senate Committee in 1916 militated more for the $250,000 appropriation than that derived from the work at the Louisiana Home. No treatment of leprosy introduced elsewhere has been more effective than that used at the Louisiana Home. Whenever new treatment has been suggested elsewhere, the Louisiana Home has tried it, but has found none better than that originally adopted in 1895-1896.

The determination of the presence of Lepra fever as a characteristic cyndrome in leprosy, and Hopkins' work in this phase of the disease, is recognized as original.

More leprosy up to the present has been cured in Louisiana and at the Home than in any other country during a like period. The systematic cure of leprosy was announced by Dyer in 1899 and fully reported in 1902.

The experimentation with attenuated snake venom (antivenomous serum) was originated by Dyer in 1896, and reported at the Berlin Conference in 1897.

The establishment of the Leper Home and the study of the cases there fixed the endemicity of Leprosy in the United States.

No other field of leprosy in the United States has been as intensively studied as that of Louisiana and no other city, state, or locality has contributed to the history of leprosy, or to the public or professional interest in this disease as has the work done in Louisiana by Joseph Jones, Blanc, Dyer, Hopkins, Duval, Wellman, Gurd, Harris, Couret and Seemann.

The material from the Louisiana Home has afforded opportunity to others for research. Fox (H) published an extensive Wassermann survey of the Louisiana Home.

The various treatments at the Home have included: Chaulmoogra oil, strychnin and hot baths (Dyer method); saponified Chaulmoogra oil subcutaneously; Mercado formula (resorcin,

camphor and chaulmoogra); Varham's colloidal solution of Chaulmoogra (France); normal horse serum; Duval's serum and vaccin; erysipelas vaccins; chlorate of potash; ichthyol; arsenic; hoang-nan; red mangrove bark; sodium fluoride; emetine; sodium salicylate; iodids; fat series (e. g. lanolin, olive oil, cod liver oil, etc.)

The Louisiana Leper Home has been model in its domestic administration and under the care of the Sisters of St. Vincent de Paul the whole atmosphere has been moral and wholesome.

The State of Louisiana need have no regrets in the way in which the Louisiana Leper Home has fulfilled its obligations and there is needed no apologist for it, even though Governor Parker may now appear to assume that role. The Home has made history and its usefulness will not end, even if a Federal administration should inherit so splendid a monument to the foresight, capability and loyal duty of the medical profession.

ORIGINAL ARTICLES

(No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. Reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.)

ON THE PREVALENCE OF CARRIERS OF ENDAMŒBA DYSENTERIÆ AMONG SOLDIERS RETURNED FROM OVERSEAS SERVICE.*

By CHARLES ATWOOD KOFOID and OLIVE SWEZY,
University of California.

Dysentery has long been known as one of the major horrors attendant upon war. Its effects are recorded not only in the roll of honor and the pension lists, but in reduced levels of health and resistance to disease of survivors and in widely spread foci of infection which follow in the wake of dispersing armies. This is especially true of the dysenteries and diarrheas of protozoan origin due to intestinal infections by *Endamœba dysenteriæ*, by the flagellates *Giardia*, *Chilomastix* and *Trichomonas*, and to a less extent, by the ciliate *Balantidium*.

In contrast with the bacillary infections producing dysentery, the protozoan infections appear, in the light of our present knowledge, to be more persistent and to pass more readily into the carrier phase in which the host may apparently have normal health, though liable to relapses. In this carrier phase the infected person is discharging intermittently great numbers of encysted stages of the of the parasite and becomes a permanent menace to the health of his family and associates as a source of new initial infections in the family and community. Medical literature of the last century bears witness to the ravages of dysentery in our Civil War and thereafter and of the efflorescence of dysentery and liver abscess in the United States after the Spanish-American and Philippine Wars, and in Germany after the return of the troops from the Boxer expedition.

The recent World War with its Egyptian, Mesopotamian, Balkan and Turkish campaigns, and its Western Front with troops of intermingled nationalities, has afforded unprecedented facilities for

* Read at the New Orleans Meeting, American Society of Tropical Medicine, April 26, 1920.

the appearance of epidemics of dysentery and for the establishment of carriers of the infective agent. The extensive laboratory surveys and determinations of protozoan and bacillary infections, which have been published as a result of the war indicate that many of the cases in the epidemics were of bacillary origin, while the fecal examinations of dysenteric convalescents, as well as those of non-dysenterics has brought to light high percentages of carriers of the dysenteric ameba.

On the other hand, the number of carriers of the bacilli of dysentery appear to be relatively few among such patients. It seems probable from the statistical results that much dysentery of amebic origin passed undetected or was masked or preceded by that of bacillary origin.

For purpose of illustration it will suffice to note the summary of the results of the fecal examinations, mainly of convalescent dysenteric patients from the Western Front, made at the Liverpool School of Tropical Medicine by Matthews and Smith (1919). They report 23,024 examinations of 4,068 cases with the following results:

Percentages of Infection by Protozoa in 4,068 Dysenteric Patients among British Soldiers at Liverpool.

Protozoan	Number of Cases infected.	Percentage infected of total examined.	Probable percentage of infection based on expectation after six examinations.
E. histolytica	494	12.1	23
E. coli	1,208	29.7	50
E. nana*	279	16.6	....
G. intestinalis	669	16.4	26.3
C. mesnili	148	3.6	12 to 15
T. intestinalis	29	0.7	....

* Based on last 1,674 cases examined.

Ravaut (1916) and other French observers noted the increased incidence of amebic infections among the French soldiers and citizens as the war progressed and traced some of the initial outbreaks to contacts with colonial troops of African origin or previous service.

The degree of infection among our own soldiers both overseas and home service is indicated by the results of examinations of returning soldiers in Debarkation Hospital No. 3, at New York

City, and of home service men of the Port of Embarkation who had not been overseas, reported by Kofoid, Kornhauser and Plate (1919). This investigation included 2,144 overseas and 559 home service men and revealed 276 and 22 infections respectively of *Endamœba dysenteriæ* or 19.9 and 3.9% in the two groups. A later report on this work by Kofoid (1920) shows infections in 2300 overseas men and 576 home service, as indicated in the accompanying table.

This tabulation indicates 297 cases or 12.8% infection with *Endamœba dysenteriæ* among the overseas men to 25 or 4.3% among the home service men, a three-fold increase. The home service group contained many men of foreign origin and a number of Florida negroes, a less typical assemblage of American citizens than the overseas troops. Furthermore, these results all rest, in the main, on single examinations. Had six consecutive examinations been made in each case it is highly probable that the percentages of infection detected would have been doubled, and perhaps trebled. The overseas men represented over six hundred different military units and included men who had not been out of Brest and Bordeaux, as well as seasoned veterans. Infections were by no means confined to men from the front. Many, but not all of the infected men who were interviewed reported a history of diarrhea or of a typical dysenteric attack, often recurrent. Very few of the men had dysenteric symptoms at the time of examination. They were in the carrier stage.

It is evident from investigations in European laboratories and from the data given above, that the War is returning into civil life great numbers of men who are carriers of the *Endamœba* of human amebiasis. If 12.8% of our approximately 3,000,000 overseas men became infected, there would be 384,000 such carriers or 768,000 if twice this percentage are infected.

An additional check on the degree of infection among soldiers of the home service group and in an overseas group with maximum exposure to infection has been afforded by a series of examinations made in conjunction with the Infirmary of the University of California and the California State Board of Health during the past year on returned soldiers who are now students of the University.

The results of these examinations are appended to the preceding table. There have been to date 154 soldiers examined for intestinal

Tabular summary of infections by intestinal parasites in 2300 overseas troops and 576 home service troops of the U. S.

Tabular summary of infections by intestinal parasites in 2300 overseas troops and 576 home service troops of the U. S. Army at Debarkation Hospital No. 3, New York City, N. Y.

CASES OF INFECTION.

				Cestoda			Nematoda			Rhizopoda						Flagellata					Miscellaneous		
	Total	Negative	Positive	Dibothriocephalus latus	Hymenolepis nana	Tænia saginata	Hookworm	Trichuris trichiura	Ascaris lumbricoides	Endamœba coli	Endamœba nana	Endamœba dysenteriæ	Endomœba gingivalis	Dientamœba fragilis	Amœba limax	Trichomonas intestinalis	Tricercomonas intestinalis	Embadomonas intestinalis	Chilomastix mesnili	Giardia intestinalis	Sporozoa	Blastocystis hominis	Phycomycete spore
Overseas	2300	763	1537	0	10	0	160	136	26	473	675	297	1	1	3	3	3	4	97	131	7	784	194
Home Service	576	243	333	1	3	2	22	14	1	92	161	25	1	1	1	3	1	4	20	37	4	181	57

PERCENTAGES OF INFECTION.

Overseas	2300	33.1	66.9	0.0	0.4	0.0	6.9	5.9	1.1	20.5	29.3	12.8	0.1	0.1	0.1	0.1	0.2	0.2	4.2	5.7	0.3	34.1	8.4
Home Service	576	42.2	57.8	0.2	0.5	0.3	3.8	2.4	0.2	15.9	27.8	4.3	0.2	0.2	0.2	0.5	0.2	0.7	3.5	6.4	0.7	31.4	9.8

Tabular summary of infections in 91 overseas troops, 34 home service troops, and 29 troops of unknown status examined at University of California, Berkeley, Calif.

Overseas	91	6	85	0	0	0	1	4	0	44	64	61	0	0	0	1	0	0	4	6	0.0	65	16
Homes Service	34	5	29	0	0	0	1	1	0	10	22	9	0	0	0	2	0	0	2	1	0	19	6
Unknown Status	29	6	23	0	0	1	1	0	0	8	14	12	0	0	0	0	0	0	1	0	0	14	1

PERCENTAGES OF INFECTION.

Overseas		6.6	93.4	0.0	0.0	0.0	1.1	4.4	0.0	48.4	70.3	67.0	0.0	0.0	0.0	1.1	0.0	0.0	4.4	6.6	0.0	71.4	17.5
Home Service		14.7	85.3	0.0	0.0	0.0	2.9	2.9	0.0	29.1	64.8	26.5	0.0	0.0	0.0	5.8	0.0	0.0	5.8	2.9	0.0	55.9	17.6
Unknown Status		20.7	79.3	0.0	0.0	3.4	3.4	0.0	0.0	27.6	48.3	41.4	0.0	0.0	0.0	0.0	0.0	0.0	3.4	0.0	0.0	48.3	3.4

Protozoa by us at Berkeley. Of these 91 are overseas men, 34 home service, and 29 as yet undetermined. The numbers of carriers of *Endamœba dysenteriæ* in the three groups are 61.9, and 12, or 67, 26.5 and 41.4% respectively. The infection in the overseas men is more than twice as heavy as in home service men. It is noteworthy that the infections by some of the other intestinal protists and by whipworm are also increased in overseas men as compared with those in the home service ones. For example *Endamœba coli* is increased from 29.1% to 48.4%, *Giardia intestinalis* from 2.9 to 6.6%, *Blastocystis hominis* from 55.9 to 71.4% and *Trichuris trichiura* from 2.9 to 4.4%

The degrees of infection detected in these examinations are, as a whole, distinctly higher than those found by us at New York. The difference results from the following causes. (1) A larger number of examinations in most cases, (2) increased accuracy in examination as the result of experience, and (3) the probability that this group of overseas men had a maximum degree of exposure in the period of greatest spread of the contagion on the Western Front and (4) possibly the longer time for the development of infections before examination.

Whereas the men examined at New York received, in the main, only a single examination, we have been able to make a total of 589 examinations of the 154 men at Berkeley, an average of 3.8 examinations per man. Only 33 of them had but a single examination while 66 had six. This increase in the number of examinations per man from about 1 at New York to 38 at Berkeley, might be expected to at least double the percentage of infection by *Endamœba dysenteriæ* detected in the examinations. We find, however, that the percentage rises from 12.8 to 67% instead of 25.6% so that other factors than the number of examinations must be operative to account for the increases in percentage. It seems probable that increased accuracy resulting from experience contributes only a small part of this.

These records of infection by *Endamœba dysenteriæ* rest upon careful indentification of the organism in the encysted stage in preparations stained in iron hæmatoxylin, as well as in the temporary iodine-eosin stain of Donaldson. The possibility of confusion with other organisms is largely eliminated by the concurrent determinations made of all other known protists in the stools.

The overseas men of this group belonged mainly to the 91st

Division which saw hard service in the Argonne drive and later on the Belgian front in the closing days of the campaign. Many of them testify to the widespread prevalence of intestinal troubles and dysentery during both field campaigns. No critical evidence is available to determine the relative amount of bacillary and amebic infections during the campaigns or at present.

This percentage detected in our overseas men (67%) is over 50% higher than the expected percentage in the men examined at Liverpool or New York. The Liverpool statistics were gathered several years prior to ours from men retired from the front at that time. Our men had the exposure to the cumulative effects of spreading contagion in the last year of the war.

Not a few of the home service men examined at Berkeley were in the Southern training camps in a territory where infection by *Endamœba dysenteriæ* is to some extent endemic, though the probability of much increase in these infections as a consequence of exposure within army camps is relatively slight owing to examinations of foodhandlers, and effective measures of fly control, which prevailed in the army camps, but less effectively in their environs.

The men examined in New York were convalescent patients in transit from Europe to various camps in the United States for discharge, and were recently from the zones of exposure to infection. The men examined in Berkeley have had an additional six months to almost a year for the parasites to multiply or die out. Evidence for so-called spontaneous cure of such infections rests in the main on an inadequate number of stool examinations.

The sequelæ of such infections are varied. The dysenteric syndrome is only one of several manifestations. The clinical histories of cases of amebiasis may exhibit abscess of liver, lungs, or brain, inflammation of the appendix, enlarged spleen resistant to quinine, long bone and joint rheumatism, and obscure and rebellious types of skin infections. The carriers we have detected exhibit none of these consequences, though some of them are clinically in subnormal health at present. Some are apparently normally robust, but all are potential sources of infection since their feces intermittently contain cysts, the cause of contagion.

The data here presented are indicative of several conclusions in regard to so-called tropical amebic dysentery.

1. The number of carriers of amebiasis in the United States

has been greatly increased by the infections in soldiers returning from overseas.

2. A larger number of carriers than has hitherto been suspected exists in the normal population in this country.

3. The dysenteric syndrome is not an essential feature of the disease and the infection is by no means limited to the tropics.

4. The carrier phases are persistent and afford possible foci of contagion.

5. The percentage of carriers relapsing or developing serious sequelæ is as yet unknown.

It is obvious that the prevalence of carriers of amebiasis in this country demands increased vigilance on the part of the federal, state, and municipal health authorities. The fact that the organism can not multiply outside of the body and that the progress of the contagion under normal conditions of sanitation is slow, makes an epidemic of amebiasis quite improbable. Its spread by food handlers, by household contacts, and, in favoring circumstances of poor sanitation, by flies and water, will make its progress all the more insidious because it is not catastrophic and because an unknown but probably large number of infected persons exhibit no symptoms of disease, or no symptoms associated with dysentery.

Increased attention is called for on the part of the practitioner in all obscure intestinal cases to the possibility that *Endamœba dysenteriæ* is the etiological factor or accessory to the disease.

It is also eminently desirable that the United States Public Health Service, the Red Cross, and other social service agencies co-operate to detect and free, as far as feasible, our returned soldiers from the incubus of this infection in a thorough and effective manner. We owe it to them and their families and to the community, and it is not impossible of accomplishment.

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TRACHOMA EXISTS IN LOUISIANA AND JUSTIFIES INVESTIGATION.*

By T. J. DIMITRY, M. D., New Orleans.

Before proceeding with my contribution I request the privilege of showing to you a few cases of trachoma. This clinical demonstration tends to lend emphasis to the subject, and my remarks can hardly be considered radical in that you are here presented with facts in proof of my assertions. Such a presentation carries greater importance than photographs and sketches.

These two children, attending school in this city are the victims of trachoma. I dare say you agree with me that they are pitiful sights. This child finds it difficult to navigate, as the lachrymation and photophobia are so great that it is necessary to keep his eyes closed. You can readily note the secretion on the eyelids. This child would bury his head in a pillow and remain there if permitted. It is impossible for him to make any progress in school and his outlook in life is very gloomy.

The condition in his brother is not quite so bad, though both are in an undoubtedly sad plight. These children have received treatment for the last three years at the hands of our very best ophthalmologists, and they have made little progress, hence it would seem that we are justified in accepting the prognosis of many who state that trachoma once developed is never cured. I wish it well understood that these children are suffering from the effect of advanced trachoma, for the lids are filled with scar tissue and we can note the pannus on the cornea. Many demand this advanced picture to enable them to make diagnosis. When the disease is acute, and when dealing with borderline cases, there is always great disagreement and insurgents offer obstruction to hygienic precautions.

* Read before the Orleans Parish Medical Society May 20, 1920. (Received for publication June 10, 1920.)

Both of these children were born in this city. Their parents and grandparents were born here—they are native Louisianians. The following question is entirely justifiable: Did their parents have the disease and did their great-grandparents bring it from the old world? Their parents and grandparents did not have it. I believe that these children acquired the disease in one of the institutions of our city, for they have been inmates of our charitable homes. Am I not justified in advising investigation?

The third is this young boy of 14. He and his parents were born in this city. This boy became infected with the disease while being treated for an interstitial keratitis. I believe that this infection occurred at the hand of my assistants or myself, or if I am wrong in that belief a very likely source of infection was through his intimacy with trachoma case number four. I have been able to discover that they occupied a single bed for a number of days while in the hospital and subsequently became infected, and still further, these children are in a *medical* ward in the hospital. All care to prevent propogation had been ignored.

This boy had a positive Wassermann and his mother and other members gave a like reaction. When I first saw him he did not have trachoma—a few weeks after the eye developed an interstitial keratitis and while responding nicely to treatment trachoma developed. His trachoma is now cured but it has left the ear marks, and the diagnosis is not to be questioned. You may also note the result of his interstitial keratitis in the other eye.

Case number four, a young boy of eight. He and his parents were born in Louisiana. He has been an inmate of one of our institutions and it appears that he developed the disease there. His family history is negative. His condition was equally as bad as in case number one. He is cured. He received ten days ago, the tarsal manipulation treatment that I advocate.

Cases five and six are cured cases of trachoma. They were both born in this city and became infected here. Case number eight is as case number two, he was born in this city.

I have presented a clinic showing that the disease exists among our native population, and will you not admit that, if this disease is what it is defined to be, then we are dealing with a very serious problem, and that it behooves us to ignore the obstructionist who wishes all evidence of its mutilating effects in order to make his diagnosis and who handicaps all hygienic progress.

All authorities accept practically the same definition: trachoma in an infectious disease of the conjunctiva and it tends to chronicity and hypertrophy of this mucous membrane and transforms portions, and at times all, of the conjunctiva into cicatricial tissue. There is a certain stage of the disease when we contend with an abundance of secretions, and through this secretion the infection is spread. The etiological factor in the production of the disease is unknown.

Trachoma is probably scattered throughout the world and is endemic in many countries. As to the United States it is East, it is West and it is North and South, and the centre is not free of the disease. There are thousands of cases in the mountains of Kentucky. Dr. John McMullen gives some very interesting figures on the subject. Dr. White says that 80% of the Indians have the disease. Others tell us that 65,000 cases are to be found in the Indian population. In Texas, New Mexico and Arkansas, trachoma is commonly noted. The ophthalmic clinics of the city of New York offer a display of the cases most instructive. In 1909, 1083 cases were detected trying to enter the port of New York. The Washington news of this day informs us that 600,000 immigrants are prepared with passports ready to enter our country. How many of these will have the disease, and how many will slip through?

Ninety per cent of the population of Egypt is suffering from the effects of trachoma. When Napoleon's army returned from this infected land seventy- percent of his soldiers were suffering with the disease. They propagated the disease throughout Europe. Eight to fifteen percent of the labor brigade that was brought into Europe at the beginning of and during the recent war was infected with trachoma. Our American Army are to be complimented for preventing the ravages of this disease by the excellent watchfulness given to our soldiers. England and France had their fears and it was only by prompt attention that history did not repeat itself.

What are the conditions in Louisiana and what precautions are taken to prevent its spread? In answer to the first we know that the disease exists here among our native population. We believe that the condition is not as bad here as in other places, though we lack proof of this, for we lack records that would give us any

information on the subject. In the Sanitary Code of the State of Louisiana added February 18, 1915, we find:

"For purposes of investigation and statistical records, pellagra, trachoma, hookworm, malaria and whooping cough are hereby made reportable diseases in the State of Louisiana, and attending physicians must report to the La. State Board of Health and to the respective local health officials all cases of these diseases in the same manner as provided in Section 13 of the Sanitary Code.

(Cards or envelopes will be furnished all physicians so as to save expense of postage.)

In a communication to Dr. Dowling, President of the State Board of Health he furnishes the following data:

Five cases of trachoma have been reported to him during the year 1919-1920.

Homer—Claiborne Parish	1
Kaplan—Vermilion Parish	3
New Orleans	1
Shreveport	1

Since this communication I have been able to report to the health authorities as occurring in my hospital work and my private practice thirty-one cases—3 of these are totally blind.

Our school inspectors are investigating this disease, though I doubt if in the last few years any work at all has been done by any experienced eye man in the schools. I know that St. Bernard Parish is possibly the foremost parish in the State in investigating the health conditions. The work accomplished in that parish is ideal. Not alone is inspection provided for but also treatment. I fear that many labor under the impression that the disease is essentially in the foreigner. Such is not the case. Again, it is often stated that it is noted principally in institutions and where large population is gathered together under unhygienic surroundings, though it is found in these places the disease is a rural disease and the census reports are convincing on this subject. The greater numbers were found among the stock raisers and agriculturists.

Is trachoma a national problem? This has been answered by enacted laws and by the assistance given by the government to prevent its spread and to render assistance to the unfortunates. We have the Federal immigration act providing for the exclusion of persons with "dangerous contagious diseases" now applying in force in respect to this disease. In 1897, trachoma was declared

a contagious disease by the Secretary of the Treasury. There are seven trachoma hospitals in the United States, three in Kentucky, one each in Virginia, Tennessee, West Virginia and North Dakota. In 1913 a law enacted in 1882, authorizing the president to employ public funds for the suppression of actual or threatened epidemics, was made to apply to trachoma. In large cities special schools and classes have been established for the trachoma children. It is well to remember the great number of Indians infected with the disease, probably 80%.

Now I ask, is it not a problem in Louisiana? The chief requirements for the prevention of any disease is the compulsory reporting to the health authorities of all the cases. This is provided for in our sanitary code but it is not obeyed. I have been able to show you a number of cases which should convince you of its existence in our state and among our native population. This demonstrates a potential danger.

I wish it understood that I do not wish to alarm, but merely to warn. Do not neglect the reporting of the cases. It is essential to the success of any campaign. Why not systematically investigate the problem in our state with the view of discovering the true condition and the method of combating it?

DISCUSSION.

D. V. C. Smith: "I seldom see a case of trachoma and rarely in my private practice. Nearly all I have ever seen have been in patients of foreign parentage with hardly an average of one fresh case yearly. I do not believe that trachoma is curable. Trachoma inevitably produces scar tissue and if there is no scar tissue patient did not have trachoma. I do not believe that the disease is prevalent to any dangerous extent in Louisiana.

Dr. J. B. Guthrie: In Camp Beauregard, Louisiana, 1700 troops from different districts of Louisiana, Mississippi and Arkansas were encamped and during the nine months in which I was connected with the Camp as a member of the Disability Board, 26 cases of trachoma were discharged from service. The majority of these cases were from Arkansas and Mississippi, Louisiana having the least.

Dr. Chas. A. Bahn: Of the 750 cases seen by me in office practice since my return from military service, there have been seven cases of trachoma or trachoma observation, of which three were old and non-contagious, two recent and probably contagious and two suspects, later proven not to be trachoma.

In the Eye, Ear, Nose and Throat Hospital Clinic, one of the largest in the city, there have been six recent cases of trachoma this year and we have performed only three tarsal excisions which operation is done in most chronic inflammatory cases of the disease.

I do not believe there are 500 cases of trachoma in the state of

Louisiana, of which 10% may be contagious. I hardly feel that we are menaced by a ravishing scourge of the disease and need not work the hardships on the community that have been done in out-bursts of trachoma enthusiasm in other cities. The researches of Kuhnt have proven that any massage treatment of the conjunctivæ or tarsus does not cure without cicatrization, does not prevent re-infection and the infection of others for a prolonged period.

PARENTERAL INJECTIONS OF COW'S MILK.

By DR. A. DARIER.

(Translation from La Clinique Ophtalmologique, by T. J. DIMITRY, M. D., New Orleans, La.)

This therapeusis was introduced by Müller and Thanner of Vienna, in 1916 (*Med. Klin.* 1916) in the treatment of the iritis and other ocular infections (see analysis of this work in detail in *La Clinique Ophtalmologique*, December, 1916).

After experiments made in inflammations, following blennorrhea, they carried their experiments to ocular infections, and particularly iritis. They obtained rapid cure characterized by the rapid cessation of the pains and of the photophobia. (The same result was obtained by us long ago, by means of the para-specific serotherapy by mouth as well as parenterally).

In the "parenchymatous keratitis," they observed an immediate suppression of the photophobia and a decrease in the duration of the affection, which becomes notably more benign, as in iritis. The intra-venous injection provokes a more violent fever but it is more efficacious, the pain oft times disappears as it does after a narcotic.

Pfluck (*Woch. f. Th.*, No. 41, 1917) speaks still more highly of the results obtained in Vienna, in parenchymatous keratitis, iritis and opacities of the *vitreous*. This action was remarkable of above all others, in a case of blennorrhagic ophthalmia with perforation of the cornea. (This is again a fact similar to the one observed by the serotherapy.)

Dimmer obtained surprising results in two cases of iritis and rheumatic kerato-iritis. In the parenchymatous keratitis, the improvement was only temporary; according to this author, paraspecific serotherapy would act like the milk.

Friedlander is reported to have cured 40 cases of old trachomas.

Domec mentions two cases of ulcers with *hypopyon* of a trau-

matic origin taken in their incipiency and cured within two or three days; the ulceration in both cases was altogether superficial and the same therapeutical result would have been obtained by the usual means. It was observed that fifteen other cases were cured with the same rapidity. In one case, however, the treatment is reported as having remained without result; finally in one case of serpiginous ulcer (the other eye having been lost due to the same affection) cure was affected in four days with satisfactory vision.

In a case of traumatic irido-cyclitis with pupillary exudate and hypopyon, one injection of milk brought the disappearance of the pupillary exudate and of the hypopyon in twenty-four hours, and the cure after four injections with V=0.8. This case is extremely interesting, likewise the following one, irido-cyclitis with hypopyon, where the first injection of milk caused the disappearance of both, the hypopyon and pupillary exudate.

A third case of the same kind is reported to have improved under the same conditions.

In four cases of irido-cyclitis of endogenous origin, the results of milk injection reported were equally favorable. Domec adds that, in similar cases, Roux' serum would have given him similar results, although less lasting.

In post-operative infections, Domec obtained eight very fine results out of ten cases treated.

In abscess of lachrymal sacs, particularly when they opened spontaneously, the pus dried up in the space of forty-eight hours, and ten days after the wound was completely healed. Five suppurative *chalazions* healed in the same manner.

Kerato-conjunctivitis, eczematous or phlyctenular—The Milk treatment,—Domec obtained marvelous results in such cases, less than forty-eight hours after the first milk injection he sees the eyes open and the pustules melt almost immediately; strumous children are cured in less than eight days. Two injections of from one to two cc., at intervals of from two to three days, are sufficient for children under ten years old. The local and general treatment must not, however, be neglected.

In two cases of parenchymatous keratitis, Domec is reported to have had good results, but the only observation he cites is not conclusive.

I have, myself, practiced numerous injections of boiled milk and

my general impression is rather favorable to this new therapeusis which offers about the same advantages as para-specific serotherapy. Later we will establish a parallel between these two medications.

From my view-point, the number of cases treated has not been great enough to permit of firm conclusions as the subject is new, and with a therapeutical agent as variable in its qualities, as is milk, purchased of the first comer, without one knowing anything of the cow that supplied it. I wish to give here only my actual impression on this subject.

I treated five cases of parenchymatous keratitis of from 12 to 23 years, of which Bordet-Wassermann test was positive plus 4; my impression is that the milk *in one case* produced a *favorable* result• while the intra-venous injections of Cn Hg seemed not to have any more marked effect as it had at the beginning. However, it became necessary to return to the specific treatment, to bring about the cure, milk appeared to have only a doubtful action.

Unfortunately, I have not been called upon recently to treat parenchymatous keratitis of tuberculous origin. I did not obtain, with the milk, the rapid cessation of photophobia and blepharospasm which I had observed after the injections of antidiphtheritic serum or its administration by the mouth.

One must not lose sight of the fact that this action of the serum is above all palliative. We will observe, however, that Walther noted a great improvement of the tubercular parenchymatous keratitis after a few injections of the antidiphtheritic serum. I prefer, in such cases, the anti-tubercular serum followed with a tuberculine treatment (see the *Clinic Opht.*, 1915, p. 613). It is probable that milk injections in such cases will have a more marked action than in the heredo-specific form.

In infectious ulcers of the cornea, the first few days, cure will most probably be effected by means of the usual "antiseptics," argyrol, sulphate of zinc, etc., combined to the use of dionin and optochin; if there is hypopyon and pain, should be prescribed with 10 to 20 cc. of antidiphtheritic serum in the twenty-four hours, during four or five consecutive days. By this means, I generally cure all infectious ulcers, in the first degree.

In more serious cases, good results can be derived from milk injections, but I must admit that where I am concerned I find this last agent in no way more effective than the injections of serum.

I recommend them, however, in all cases where serum or anaphylactic accidents are feared. In serious cases, I have never been able to accomplish cure, with milk injections alone, they did not cause the hypopyon to disappear and did not stay the progress of the ulcers. Cure had to be perfected by means of cauterization with the galvano cautery, and once I had to have recourse to Sæmisch's incision. Almost all favorable observations published cover benign cases, or at least those ulcers in the first degree in which the corneal erosion, sometimes very extensive, does not progress into the stroma of the cornea. These cases I repeat are the easiest to cure, by any means resorted to.

The number of cases of infectious ulcers cured by para-specific serotherapy are very numerous, if we are to believe the authors cited, as far back as 1911.

In post-operative and traumatic infections of the cornea, milk injections will serve the same purposes in cases where serotherapy, so simple and so effective, by way of the mouth, will not have given entire satisfaction.

The same will apply in cases of iritis or iridocyclitis produced by endogenous infections: syphilis, tuberculosis, gonorrhea, etc. In the last two forms, and particularly in ocular tuberculosis, I have had the impression that milk injections have a favorable action, but inferior, however, to that of antidiphtheritic serum.

In a case of intense iritis, aspirin having failed to give results, I had the patient take a serum (10 grm. of serum each 24 hours); in four days all pain had ceased, and the pupil dilated well, without atropin. I then had the idea of resorting to another milk injection of 4 cc. and discontinue the use of the serum. There occurred a new and violent recurrence of iritis. The serum administered, soon restored and improved conditions with prompt cure. It is possible that further injections of milk would have been necessary, but the patient objected, the first one having provoked violent fever.

In intra-ocular diseases of the eye: chroido-retinitis, optic-neuritis, etc., results were very variable.

In one case of macular choroiditis, most probably tuberculous, in a gouty youth with tuberculous antecedents, after a complete failure of sub-conjunctival injections of cyanide of Hg. and little effects from colchicine, a great improvement was manifested *after* a series of 10 injections of milk, of 5 cc. (post vel propter hoc?)

In another case, without any characterized antecedents, the perimacular choroiditis did not cease to make progress in spite of twelve injections of milk etc.; the patient can hardly see to go about.

In affections of the *conjunctiva,* milk injections are said to have given at times brilliant results, and at others results were almost nil; thereby, opinions are somewhat divided in that respect. Here again, the effects correspond to those obtained by paraspecific serotherapy. In fact, in blennorrhagic conjunctivitis with corneal complications, results obtained from injections of antidiphtheritic serum have often been most favorable; ulcers of the cornea heal easily after a rapid decrease of the conjunctival secretion. (See *la Cl. Oph.,* 1899, No. 1; 1903, No. 5, etc.) Lagrange and Teuliers observed two cases of rapid improvement in purulent ophthalmia with ulceration of the cornea. (See *Clin. Oph.,* 1910, p. 577.) Galenga relates several favorable cases (*la Clin. Oph.,* 1910, p. 598); Frogier, also, publishes a very interesting observation. (*la Clin. Oph.,* 1909, p. 607).

For my part, serotherapy is a precious means in purulent conjunctivitis, the secretions are rapidly reduced, photophobia disappears promptly and at the same time that the ulcerations of the cornea heal.

These are the same results attributed to milk injections by Friedlander, Rosenstein, etc., in granular conjunctivitis. Orlando Pes obtained from sub-conjunctival injections of serums, a rapid resorption of the inflammatory products. Piccaluga (*la Clin. Oph.,* 1910) combined sub-junctival injections of anti-diphtheritic serum, with the same injections, hypodermically, in the treatment of granular conjunctivitis with *pannus.* The effects were surprising.

For my part, I treated only two old cases of trachoma, with milk injections. The patients got relief, but I cannot say that they were cured.

In the ophthalmic zone, paraspecific serotherapy administered the first days often gives remarkable results; cessation of pains, prompt healing of the pustules, and disappearance of the tumefaction of the tissues. In one case of that kind only, did I use milk injections; the results were rather favorable after fever. This is all I can say until I have more ample information.

Skin Affections: Schrameck related a case of vegetating pemphigus of a serious character, in which he was successful, with

parenteral injections of serum, and with the assistance of tuberculin obtained complete disappearance of the principal phenomena. There was a recurrence of the trouble after several months. I, myself, observed a case of impetiginous eczema which had covered a baby's entire head, into a ball of scabs. After a few injections of the antidiphtheritic serum, all the scabs dropped off and in less than a month the face of the child had resumed its normal aspect.

Domec observed that in eczema of the eylids and of other parts of the body, injections of milk bring about a drying up of the surfaces, then the scabs drop off and the skin resumes its normal aspect.

I saw ulcers of a lupic tuberculous aspect, 20 c. high by about 15 wide, on the leg. The patient was thirty-five years old and had gone through the most varied treatments at the St. Louis Hospital, including radium and X-rays. Believing it to be of a tuberculous origin, I tried frictions of guaiacol, without favorable results.

I then gave the patient the milk injections. After the fifth, in the space of three weeks there was a notable improvement and at the end of a dozen injections the entire surface was healed, the edema of the leg had entirely disappeared and the patient walked well, without pain and without fatigue.

I left the patient, for a six weeks vacation; on my return I was surprised to find him completely cured. Today, after nine months, the ulcer is still healed, but on the lower portion on a line with the leather on the back of the shoe heel, can be seen three or four prominences, scabby tuberculoids. The patient still received one or two injections of milk monthly, of 5 cc.

In articular rheumatism, milk injections had given good results to different authors. Müller and Weill noted that fact particularly in cases of blennorrhagic arthritis.

I tried injections of milk on patients suffering with albuminuric retinitis, but I noted no improvement, neither in the sight nor in the general condition. It may be that I used too small doses, 2 to 5 cc.

Clinical observations call my attention to peculiar effects of milk injections. A young woman, twenty-two years old, 3½ months pregnant, suffering with parenchymatous keratitis, with W +, not having been able to give her more than three intra-venous injections of enesol of 5 cc., the patient experienced something like uterine colic and she had me observe that her breast had become

hard and almost painful. I ceased these injections to take up intra-muscular enesol. At all events, the milk injections had not brought about reduction of the photophobia; it is even at that time that the second eye became involved. After five months of mercury treatment, the corneas are completely clear, the patient goes about by herself and sees to read with + 4 (atropin); milk may have had a share in this cure.

Another patient with serious infectious ulcers of the cornea, who did not derive any benefit from the milk injections (rather painful), appeared quite satisfied with the treatment because she attributed to it her being cured of *leuchorrea* which had troubled her for quite some time. I very naturally thought that these milk injections could have a special action on the genital organs of the woman, and in cases where the intra-venous injections of enesol increased menstruation and made it more frequent, I noted that hypodermic injections of milk counteracted this effect. I could then continue the injections four weeks without stopping, whereas previously I had to suspend them every fifteen days.

Another woman called my attention to the fact, that since the injections of milk she did not have the abundant flooding caused by a uterine fibroma. It is now three months since she has been compelled to remain in bed at period of menstruation, as she had been compelled to do for some years past.

Gynecologists might derive benefit from these observations, due to chance.

Grippal Infections: Milk, having a leucogenic and antitoxic action, very similar to that of antidiphtheritic serum, could not fail to be experimented with, in a number of diseases, both infectious and epidemic. In Germany, it was vaunted against rheumatism, against the most varied manifestations of gonococcic infection. In France it was employed to fight grippal infections, and the most severe. If we must believe Dr. Gallois, head physician at the hospital of contagious diseases in Dijon, the results obtained surpassed by far all those obtained by all other treatment, including colloidal metal. Up to October 15, he had treated over 600 cases of grippe with a death rate of 18%, when Dr. Domec proposed to make experiments with lactated injections. He noted in the first cases, that in the few hours that followed an injection of 5 cc. of milk, a reaction was produced and the following day both the temperature and the pulse had lowered, dyspnea was at-

tenuated, cyanosis of the lips disappeared, and a feeling of comfort experienced by the patients. Lactated medication was then systematically followed in all cases where condition was critical, results were more rapid and more satisfactory. The younger subjects were those that reacted the sooner; this reaction is necessary and is almost always followed by a notable decrease of the fever symptoms. In older patients, particularly those with arterio-sclerosis, the action is less pronounced. One is compelled to recognize the action, manifestly antitoxic of milk, ridding the patients of their toxemia and curing rapidly, their local lesions.

Since three months that he is treating serious cases of grippe with milk, has Dr. Gallois observed in more than three hundred cases after effects or secondary complications, such as microbe infection of the lungs, bronchorrea, dilatation of the bronchial tubes, chronic broncho pneumonia, so frequent and so severe, following the actual epidemic of grippe. It must be observed that tardy application in secondary thoracic complications, the lactated treatment is not effective, a formal contra indication is tuberculosis. To obtain a rapid and favorable result, the treatment must be applied as near the incipiency of the disease as possible.

Observations made had bearing on over 300 cases, over one-third of which had broncho pneumonia or bronchitis complicated with pulmonary congestion; almost all of those who on their arrival did not present signs of asphyxia, were rapidly cured; once more, we were not accustomed to obtain such results.

I said in 1912, if there is infection of any kind, and the patient is given serum from a sound animal, he will thus receive a certain quantity of elements of defense, but if he is given the same dose of serum from an animal actively immuned, the elements of defense will be infinitely more numerous and more powerful. In 1901, Talamon was already bringing to light the successful effects of antidiphtheritic serotherapy, in pulmonary infections, all of which reduced the mortality by two-thirds on a series of 105 pneumonia cases; twenty-four hours after, the temperature had already decreased.

Since then, these experiments have been confirmed by many observers, but there is always fear of serious accidents. However, when the practitioner will be penetrated with the idea that a simple potion of the serum is the most powerful biological and anti-infectious tonic, he will not hesitate in giving his patients the benefit

of the treatment at the same time very agreeable and free of danger.

Paton, who for quite some time has been using serotherapy by the mouth, says he has never lost a single case of broncho-pneumonia, not even after the measles.

Personally, I have administered the serum by the mouth in many cases of grippe or broncho-pneumonia, with the most encouraging results. This treatment could be easily combined with milk injections. Reactions, produced by the injections of milk, are numerous and varied. The injection itself is not particularly painful, particularly so if the needle is not blunt. It is only a while after, the patient experiences a sensation of bruise more or less violent. In very stout persons, with the skin drawn tight, there is a local swelling and hardening, both apparent and painful.

The fever reaction is variable, according to the individual, but it is always appreciable by the thermometer after the fourth or sixth hour, it varies from 38 deg. to 41 deg. There is ofttimes headache and nausea, even hallucinations and delirium. But all these symptoms disappear as soon as the patient will have slept the second part of the night.

The hyperthermia, according to Domec, is often in keeping with the general conditions of the subject, scrofulous, debilitated, etc., etc. The following day there still remains a feeling of bruise on a line with the injection, and certain movements of the leg are still difficult and painful.

Personally, I have never observed serious accidents, but Domec noted cases of varied tolerance; one patient, after the sixth injection, suffered with insomnia and grew very thin, which necessitated the suspension of the treatment. In another case, the seventh injection, there occurred an immediate congestion of the face, the lips became cyanosed, nausea, pulse hardly perceptible, numbness in the upper limbs. Normal condition was restored after fifteen minutes. A strong feeling of fatigue persisted during 48 hours.

The first hypodermic is usually more painful than the following ones, therefore it is best to inject only 3 cc.. the first time, and if the reaction is vivid, 4 cc. the second time, and finally 5 cc. the third time. In Germany, the doses most highly recommended go as high 10 cc. The first ones are given at intervals of three or four days; after the fourth, only one a week is given.

The intra-venous injections have been too little experimented

with to recommend them, as the accidents mentioned by Domec may have been caused by the penetrating of the milk into a vein.

Sub-conjunctival injections of milk have given very good results, according to Gaupillat.

Respective advantages and inconveniences of milk injections and paraspecific serotherapy:—

Milk taken by the mouth has practically no therapeutic action, whereas Roux serum has a very manifest action. By enema, the effects are much more marked.

Hypodermically, milk often provokes pains locally, that are likely to last two or three days, and condemn the patient to immobility; febrile reaction is often high, though syncopal accidents rare.

Serum offers none of these accidents, with a therapeutic action almost identical; but serum accidents occur at the end of the seventh day, eruptions and swelling of the legs.

In intra-venous injections of milk, especially if it is not well filtered, a reaction is provoked, sometimes very vivid, going as far as nausea, syncope, etc.

Roux serum offers none of the above inconveniences, is well stood intra-venously without any reaction, unless there be anaphylactic accidents, which is exceedingly rare. The serum, thus injected, manifests its anaphylactic action less than an hour after, whereas hypodermically the anaphylactia is manifested only after the third hour, and only five or six hours after when the serum has been taken by the mouth.

With milk, the decrease in the pains is produced only the following day, after the reaction has taken place.

It is apparent that the injections of milk and the injections of serum, more yet than the injections of colloidal metals, have a therapeutical action, the most manifest and the most precious. They present respective qualities that may offer various indications. Thus, the possibility of being enabled to administer the serum by the mouth constitutes in its favor a marked advantage, this mode of giving it being the easiest, without any contra indications.

The treatment can therefore be thus started, to be completed later, if its action is not sufficient, with injections of milk. In serious cases, the two methods can be alternately applied, according to the principles established in the course of this work. I would thus proceed in the following case:

Mrs. A. was operated for the cataract under favorable conditions on March 1st. The first days, all goes well, but the patient suffering

very much with rheumatism for quite some time, complains on the fourth day of pains in the abdomen, the following day, violent preorbital neuralgia, the eye is very red with a **chemosis**, especially in the lower portion, no sign of infection in the wound which is completely healed, but the aqueous is cloudy, flaky, and the patient who previously could see the fingers very distinctly barely sees the flame of a candle. The patient is taking aspirin since the day before, I prescribe a potion of antidiphtheritic serum 10 cc. daily. The following day, the condition is still worse, in addition to the serum, subcutaneous injection of 5 cc. of milk; two days later, other injection of 5 cc.; likewise, two other days later. That day, I note a marked improvement, the cornea, which still remains very transparent, permits one to see that the abundant exudate of the anterior chamber begins to absorb itself, and the pupillary orifice is seen for the first time, the chemosis has notably decreased, the patient sees a little the movement of the hand, the se-um potion is continued. As a precautionary measure, a 2 cc. injection of turpentine is given in the left thigh. After seven days, after three injections of milk and six potions of serum, all trouble of the aqueous humor has disappeared, the iris has recovered and almost of normal tint; but the pupil is obstructed by a whitish exudate, very good light perception, the turpentine has produced no abscess.

Mode of action of parenteral injections of milk:—

We have known for the last twelve years, that antidiphtheritic serum taken by the mouth has a marked therapeutic action. Such is not the case with milk which, taken by the mouth, is an excellent food, and aside from its action of being an antidote to poison does not appear to possess any particular therapeutic properties.

Nolf and R. Müller have studied the action of several albuminoids in parenteral injections, on localized inflammatory processes and have mentioned good results in blennorrhagic complications, *bubos,* staphylogenic processes and others. Leaning on clinical observations, believes he can explain the effects produced, by an increase of the hyperemia, and by the transudation in the seat of inflammation; other processes, and above all hyperthermia and leucocytosis act an important part. He believes that vaccins, aside from their specific actions, exercise a marked action by products that are not specific of the decomposition of albuminoids which provoke hyperthermia.

But it is not only albumen that acts in milk, there is also the lactose fats, salts, without counting the ferments that may be considered as anihilated by ebullition twice repeated. There are also microbes, living or dead.

Since Metchnikoff's remarkable discoveries, it is universally admitted that the essential element of defense of the organism, is the white corpuscle, whether this acts by digesting the microbe or neutralizes by its secretions the microbe toxins or others.

The important question in all infections is to increase the organ of defense, bacteriotropic antiseptics not having as yet demonstrated their efficiency.

All means that increase the number and activity of the leucocytes constitute a previous therapeutic force. The higher the leucocytosis, the better is the defense of the organism.

The leucogenic medicines are listed by Audoin in the following order, according to activity:

1. Physiological serum between 7 and 12% (weak).
2. Colloidal metal (weak).
3. Antidiphtheritic serum (medium strength); it is more powerful than the colloidal metals, whereas antistreptococci serum is little or not leucogenic, that is what explains the weak action of these serums.
4. The neucleinate of soda would be the very best leucogenic, it provokes a strong reaction four hours after the injection—hypodermical—(sooner than intravenal injection) there is tachycardial chill and fever at 40 deg. and over. Unfortunately, the neucleinates are unstable.
5. Finally, the most powerful leucogenic would be turpentine in hypodermics; there is abscess formation (said of *fixation*) with abundant suppuration.

Audoin does not make mention of albumen or milk injections, but later (both) can be placed alongside the serum as leucogenics of medium power.

Is this the only way of explaining the action of the Milk? Most certainly not! According to Konteschweller, it is thermic reaction which would be the principal cause of the therapeutic action of parenteral injections of peptones and of milk; without thermic reaction there is no medicinal action, says he, and on this he bases a theory which he names pyreto therapy. This might prove true for the peptones, nucleinate or milk but not for the injections of serum and much less when these serums are given by the mouth and are accompanied by a prompt and marked therapeutic action as in the case of iritis cited above. The question is therefore complex, one must not be exclusive but seek the special indications of each agent so as to be able to alternate or cumulate their respective action. Milk is an agent, too complex and too variable, according to the source it comes from. The cow that supplied it may be or may have been tuberculous; in the second

and perhaps in the first alternative her milk may have a certain action on ocular affections tributary to tuberculosis.

To study well the therapeutic action of milk, it would be necessary to know the action of each of its elements; albumoses, salts, fats, lactose and ferments. Ferments were studied up by Blondel, then by Barialari, who gave injections of filtered sour milk (the residue of clabber). They conclude that milk serum from a normal cow is *hypotensor* but only in *hypertendous* persons. The other components of milk remain to be studied.

In the meanwhile, it will be necessary that all observers use milk prepared in the same manner.

The cow's teats would be asepticized as well as the hands of the one that would milk her; the milk would be received in a sterilized receptacle, immediately stopped up with the batting, then immediately brought to the boiling point during fifteen minutes, and after cooling boiled a second time, and then filtered with Chamberland's bougie, and then put up in a vial containing 5 to 10 cc. and dated.

A more simple method of sterilization was tried at Liverpool, by electricity on a large scale; according to Priestley, milk is thus deprived of all infectious organism, notably tubercular baccili. Unfortunately, the author gives no detail as to the electric method employed.

Small vials could also be prepared, of sour milk, sterilized by electricity and not by heat, thus preserving the action of ferment. Cow's milk tuberculinized could be tried in ocular tuberculosis.

Condensed milk diluted to a 10th, could be put to the test.

Conclusions: Injections of milk are one of the most energetic stimulants of the general defenses of the organism. They act by activating the leucopoiese and the phacocytose, and also by provoking a temporary febrile condition.

Combined with serotherapy by way of the mouth, they constitute one of the surest means of fighting the most varied infections, and particularly so, infectious ulcers of the cornea, iritis, traumatic or post-operative infections.

In such cases, an average of 10 cc. of serum will be given each twenty-four hours, and every second day a milk injection of 5 cc., of course without neglecting the local treatment.

In the treatment of parenchymatous keratitis, and in granular

conjunctivitis, the effects obtained are very encouraging, but opinions are still divided on this subject.

In grippal infections, broncho-pneumonia, etc., in gonococcic complications, rheumatism, etc., the combination of serum and milk are more useful.

THE AMERICAN SOCIETY OF TROPICAL MEDICINE.*

By HENRY J. NICHOLS, Major, Medical Corps, U. S. Army.

To the Members of The American Society of Tropical Medicine:

To begin with, I wish to thank the members for my election to the office of President of the Society. Insofar as this position is a personal reward for work, it is appreciated, and will be looked back upon with satisfaction. Insofar as it carries responsibility, I am glad to do my share in attempting to direct the affaris of the Society along useful lines. The responsibility apparently is considerable. In fact, a year ago I was told that the prognosis was bad. I began to feel that my only function might be to conduct the post-mortem, but it is evident that the patient is making a good recovery from the depressing influence of war and pestilence, and, like other convalescents, is undergoing a rebound to a better state of health than ever. Under these conditions it seems indicated that the presidential address at this sixteenth meeting should be devoted to the affairs of the Society rather than to any special professional subject.

It may well be asked why a Society which has had among its recent presidents such leaders as Gorgas, Thayer, White, Stitt, Strong, Craig, Rosenau, Ashford and Bass should ever be thought to be in a precarious condition. The answer is two-fold: First, the nature of our work; second, the prevailing state of national morale. American specialists in tropical medicine are comparatively few in number and are widely scattered, and it is difficult for any considerable number of them to meet at the same place at the same time. This fact makes some of our meetings very small as compared with those of the more cosmopolitan and fundamental specialties. We have about 108 active members, and our attendance is usually about ten to twenty. In comparison with the crowds so familiar in some medical meetings and so dear to Americans,

* President's Address, delivered at the 16th Meeting of the American Society of Tropical Medicine, held at New Orleans, April 26, 1920.

this handful might seem a poor showing, but it is really only normal. Small meetings are a handicap which we should accept, and it is peculiarly true of the worker in Tropical Medicine that he must be prepared to stand on his own feet scientifically and morally. Soon after our last annual meeting I sent a circular letter to all members asking for support in making a fresh start for the Society. A number of gratifying replies were received and some of these were illuminating as showing the peculiar character of our work. It appears that many members are unable to attend meetings or contribute to the program, but are sufficiently interested to keep up their dues. Many physicians are directly concerned with tropical medicine only a few years and some have chiefly an academic interest, but still for various reasons desire to be members. These members I believe should be held, and if anything in the circular letter gave any other impression I now wish to correct it. Anyone who has other qualifications and is willing to keep up his support should be welcome.

Our relatively small meetings make it especially necessary to have some binding tie in the form of publications. The single annual volumes of transactions which for several years were edited with such devotion by the Secretary, Dr. Swan, served a very useful end in keeping members in touch with each other. Then a monthly was started, but unfortunately for personal reasons could not be continued. Recently the *New Orleans Medical and Surgical Journal*, through the public spirit of its editors, Dr. Dyer and Dr. Chassaignac, has carried us, and we are grateful for this assistance.

In looking to the future the Council has made efforts to find a more distinctive form of publication. The most feasible plan at present seems to be to publish our transactions as before in a single annual volume. Our income from dues warrants such an undertaking, and it will begin with this year. Eventually we may look forward to a special Journal, possibly under the wing of the *Journal of the American Medical Association.*

The second circumstance which caused our slump was referred to as the low state of national morale. After superhuman efforts of the War, there has undoubtedly been a general let down of interest and effort which is felt in our Society. Concentration and sustained effort have naturally been succeeded by a certain amount of indifference, but they are not lost qualities and will function again by degrees. The tremendous resources of our country in

natural forces and human energy will find expression and it is our duty as well as desire to play our small part as a Society in the Nation's life as best we may. The best way to be good social creatures is to organize and work in common on a common task. The tasks in tropical medicine for Americans are many, and our traditions already established in a short time are great. In the face of our national future, the Society, as the only national organization of its kind, is called on to put its affairs in order and go forward.

We now have 108 active members, 19 corresponding members, and 39 honorary members. We may look forward as a result of past experience, (1) to a small number of active younger members to carry on the meetings and publications. These members should be recruited from Government services such as the Army and Navy, the Public Health Service, and the Government services of our foreign tropical possessions; from physicians to tropical industrial companies; from practitioners in the South and in the Tropics; from medical schools and institutes in the Tropics and from schools of tropical medicine in this country. (2) To a larger number of older active members who will support the Society by membership, counsel and occasional attendance. These members will come from the same sources as the first group, or be graduates therefrom. (3) To corresponding members who will occasionally contribute to the meetings and give us points of contact with other countries; and (4) honorary members who will be a source of pride and stimulus. We also have our valued membership in the Congress of American Physicians and Surgeons, largely through the interest of ex-President Thayer. This membership should also stimulate us to live up to its standard.

In order to increase its membership and attendance, it has been proposd at different times to make the Society over into one of Preventive Medicine. But this field is already occupied by one or more Societies, while in tropical medicine we stand alone and have our own sphere.

It has also been proposed to enlarge our membership by taking in active members from Central and South American countries. To take such members as are qualified as Corresponding Members would certainly be desirable, but our Constitution clearly limits our active membership to American physicians. This is the American

Society of Tropical Medicine in the sense of the word as used by Secretary of State Hay.

Our future policy in regard to relations with workers in tropical medicine of other countries will naturally reflect national policies. It is not for us to decide these policies in advance. Individually we may and should have our own views, but our position as a Society should be in harmony with the national spirit and with the attitude of the majority of societies in the Association of American Physicians. At present, since our position as a nation is not yet closely differentiated, we should do what is nearest to hand—namely, to begin with our efforts, like our charity, at home.

The past two years have seen what is apparently an epoch in American Medicine—the discovery of the long sought cause of yellow fever by Noguchi. This discovery was made possible by the organization of the American Rockefeller Health Board and Institute. The findings at Guayaquil, which were reported at the last meeting, were confirmed at Yucatan this Spring, and Dr. Noguchi is at present in Peru investigating another outbreak. While adding more laurels to his eager and resistless spirit, this investigator has enlarged knowledge and given us more control over nature. In connection with the same plan of work, General Gorgas is heading a party which is already en route to Africa to attempt to settle the question of the existence of yellow fever in Africa.

It remains to thank our hosts for the arrangements for this meeting. The last meeting in New Orleans, under Dr. Thayer in 1911, was one of the most successful of our history. The present one, now seventeen years since the Society started, is held here again and naturally so as this is the natural headquarters of the Society. The Society looks to New Orleans and Tulane University to lead in Tropical Medicine. The Secretary-Treasurer, Dr. Simon, is responsible for the program arrangements and all the details of reorganization of the Society and deserves our especial thanks.

REPORT ON LEPROSARIUM, ISLAND OF CABRAS, PUERTO RICO.*

By JOSÉ A. DIAZ, Chairman.

Translated for the NEW ORLEANS MEDICAL AND SURGICAL JOURNAL by LODILLA AMBROSE, Ph. M., New Orleans.

[212] The committee now reporting complied with action taken by the Commission, and went on the afternoon of February 1 to the Lepers' Colony located on the Island of Cabras with the purpose of investigating from the sanitary, medical and social point of view the location and conditions of the life of these unfortunate beings. The committee found 41 lepers—15 women and 26 men—with two servants, a man and a woman, and under the direction of a practitioner in permanent residence. These individuals occupy two cement buildings, one for men and one for women, situated at the two extremes of the island, and also various huts of wood for the cases which are kept in bed by physical conditions. There is a small building which is used as infirmary and kitchen, and there are also various latrines on the edges of the little island and these drain into the sea; there is a cottage occupied as a dwelling by the practitioner, and a place for collecting rain water and this is the only source of this precious liquid for the island.

The huts occupied by the lepers are small with sufficient space for a bed, a table and a chair, disagreeable in aspect by reason of the filth and neglect of the linen, and there those unhappy people agonize in the process of dying more than living, without the sanitary and medical attention which they deserve, and at the mercy of two servants, kind but ignorant of all that relates to hygiene and medicines.

The buildings of rubble-work which the lepers occupy as dormitories are in very bad condition, unclean and unhealthful.

The infirmary and kitchen are in the worst of conditions; the latrines, old huddled huts, urgently need repairs; the quantity of water which the place for rain water can hold is insufficient for meeting the necessities of the colony, and it would be a real agony, if—as unfortunately often happens in Puerto Rico—it stopped

* Informe del cómite nombrado por la Comisión de estudio e investigación de enfermedades trannsmisibles, con el fin de investigar sobre el terreno y del modo más exacto, las condiciones en que se desarrolla la vida de los leprosos bajo el punto de vista sanitario, médico y social. (Dictamen leído ante la reunión científica de la Asociación Médica del Distrito Notre, Marzo de 1918.) Bol. Asoc. Méd. de Puerto Rico, San Juan, 1918, xiv, 212-215. Copy used lent by Medical Society of City and County of Denver, Colorado. Pages of the original are given in square brackets.

raining for a time, because the lack of this liquid would make itself felt immediately, and it would be necessary to carry it from this city, which would be difficult of accomplishment owing to grave material and economic hindrances in transportation to that island.

[213] The poor and dismal aspect of vegetation demonstrates the sterility of that sandy, rocky soil; it is evidently impossible to cultivate useful vegetables, or to install gardens for brightening the utter isolation of those unhappy people.

The impression received by this committee is one of painful commiseration for those beings, condemned to live in exile, apart from the world, separated from their families and friends, lost to all hope of returning to home and its affections, damned to be forgotten by all, worse treated than the most hardened criminals yet innocent, with no other perspective before their eyes than the tombs destined to receive their mortal remains.

This situation of the Lepers' Colony in the full light of the twentieth century compels us to turn our faces toward the primitive epochs, and by a phenomenon of atavism there are reproduced in Puerto Rico the events which took place yonder in Palestine before the Christian era, and in Europe from the sixth to the fifteenth century, when leprosy was recognized as the most dangerous disease known in history. To be leprous and to be driven off by the whole world, were the same thing. The places set apart for lepers were avoided like mouths of hell. The lepers could not cross the dividing line without the risk of being killed instantly. If a stranger, in good health and ignorant of the reclusion of these beings, entered their camp, he had to stay there. So rigorous were they with lepers that they compelled the person attacked with this disease to cover himself with a sheet, leaving only the eyes showing, and to carry a bell which by its ringing would announce to passers-by his presence, and to give them opportunity to flee in time to avoid infection. Civilly, the leper was considered dead. Property passed to his heirs; his wife remained free to contract marriage, and when he left for the lazaretto, prayers were said and a shovel of dirt was thrown after him to make the ceremony complete.

The conditions found in the Lepers' Colony of Puerto Rico are even worse, because, although in that epoch those who suffered from this disease were persecuted, they could still move over a larger extent of territory, and could communicate with the outside

world and ask and receive aid in case of emergency, a cyclone for example; but on that island under such conditions they would be abandoned to the mercy of God.

There is another matter of great moral importance for the department of health and for society, which the committee ought to touch upon, namely, the practitioner charged with watching these patients and over order and [214] discipline in the colony, is not able alone and especially at night with all his efforts to prevent clandestine communications between the leprous men and women. The colony might be converted into a brothel, and if the theory of the heredity of this disease is true, the result would be that—contrary to the direction of our efforts—we would be contributing to the perpetuation of the race of lepers.

In consequence of the emanations of the sea and the great quantity of sodium chloride which constantly saturates the surroundings in that island, it may be that, acting on the ulcers of the skin and of the mucosæ as an electrolytic and dialytic agent, it aggravates their suffering by preventing the cicatrization of the ulcers. It may be that this new idea deserves study.

On the other hand, the means of communication with this island are not only bad but perilous to the life of those who expose themselves to traveling in small boats across an arm of the sea always agitated and wild. From this cause several persons have perished, among them an employe of this department. And these facts make it impossible to find a physician disposed to visit the island daily, which is to be desired if we wish—as we ought—to attend the lepers in an efficient manner.*

[215] The leprosarium ought to possess all the conveniences and modern equipments for the care and treatment of the disease and for maintaining the patients in good physical and moral condition.

Leprosy is not according to any concept invariably fatal, and we ought to organize the asylums for lepers on the same plan as the modern sanatoria for tuberculosis, so that they can be cared for and educated by the same methods that are adopted for the tubercular.

Therefore, and as a result of our investigation, we recommend, that, through the commissioner of health, the legislature be requested to transfer the Lepers' Colony to a suitable location on the Island of Puerto Rico, where may be installed a modern sanatorium

* Some general statements about leprosy omitted.—Translator.

for lepers. We further recommend that there lepers should be treated in accordance with the precepts of modern sanitation and with the means which therapeutics offers us, and that this disease be studied and investigated in a scientific manner, since we do not know how it is transmitted nor do we have an effective remedy for curing it. It might happen that by constant work and by putting faith in God we could succeed in surprising the world with a discovery of great utility to humanity.

COMMUNICATION

BUREAU OF THE PUBLIC HEALTH SERVICE.

Washington, June 5, 1920.

To the Editors, New Orleans Medical and Surgical Journal:
Sirs:

On account of the large number of arsenic preparations which are being exploited for the treatment of syphilis, the United States Public Health Service has considered it desirable to issue a ciruclar letter, copy of which is inclosed, discouraging the indiscriminate use of untried preparations.

Attention is especially invited to the fact that provision is made for the experimental use of any preparation under conditions which will make the results of such experiment available to others than the physician immediately concerned.

I shall be glad to have you give the circular letter and this letter of transmission publicity.

Very truly yours,

H. S. CUMMING,
Surgeon General.

BUREAU CIRCULAR LETTER No. 219.

Medical Officers, U. S. Public Health Service and others concerned:

Your attention is invited to the extensive exploitation through advertisements in professional journals and otherwise of various arsenic preparations which are not related to the arsphenamine group. The preparations referred to are sold with claims in regard to their value in the treatment of syphilis, which are unwarranted.

In the opinion of this office it is in the interest of all concerned that the subcutaneous, intramuscular or intravenous use of arsenic in the treatment of syphilis be confined to preparations of the arsphena-

mine group as these agents are of established value and are produced under the regulations of the Public Health Service. The following firms are now licensed for the manufacture of arsphenamine and neo-arsphenamine:

Dermatological Research Laboratories,
1720 Lombard Street,
Philadelphia, Pa.

H. A. Metz Laboratories,
122 Hudson Street,
New York, N. Y.

Diarsenol Co., Inc.,
Buffalo, N. Y.

Takamine Laboratories,
Clifton, N. J.

The Lowy Laboratory, of Newark, N. J., has been granted a license to prepare a stable solution of arsphenamine.

It is not the desire of the Bureau to limit clinicians in the choice of agents of recognized worth but in the case of arsenic preparations, not members of the arsphenamine group, the available evidence indicates that their routine use is inadvisable in the treatment of syphilis. If it is desired to use any of these preparations in a purely experimental way previous authority from the Bureau should be secured. Applications for this authority should be accompanied by a statement as to the composition of the drug including the structural formula and the reason for its use. All information available on the value of the preparation should be forwarded.

Receipt of this circular should be acknowledged and marked "**V. D. Division.**"

H. S. CUMMING,
Surgeon General.

BULLETIN OF THE LOUISIANA STATE MEDICAL SOCIETY.

By P. T. TALBOT, M. D., Sect'y-Treas.

The Orleans Parish Medical Society gave an informal dance, on Wednesday, June 23, 1920, at its old domicile 141 Elk Place, just as a farewell to the old home and to have the ladies remember it with the same fond memories that are stamped in the minds of each and every member of the Society.

The halls and rooms of the domicile were very tastefully decorated, numerous palms and varied species of foliage lending a most pleasing and artistic touch to the scene of merriment.. Harmonious reflections of the rainbow, indicated by the beautiful sum-

mer gowns of the fairer sex, glinted here and there as they tripped fantastically to the strains of an extensive orchestra.

Nature, as though in marked approval of the event, lent her cooling Southern breeze throughout the evening, and, aided by the most choice refreshments, thereby changed a much-feared warm summer evening to one delightful beyond all anticipation.

For many, particularly the dancers, the evening came to a close much too soon, and I might add that no one who participated in the pleasures of the occasion will ever forget June 23, 1920, and the "Old Home" of the Orleans Parish Medical Society.

NEWS AND COMMENT

TULANE COMMENCEMENT.—The eighty-fifth annual commencement exercises of Tulane University was held on Wednesday, June 9. An interesting program was arranged, which included a statement by president A. B. Dinwiddie on the financial status of the university and an appeal for funds to form an endowment to carry on the work of education. The session just closed proved one of the most successful in the history of Tulane, there being an unusually large number of graduates in all the colleges and schools of the institution. In the college of medicine the number of graduates receiving degrees were as follows: School of Medicine, Doctor of Medicine, 81; School of Pharmacy, Graduate in Pharmacy, 10; Pharmaceutical Chemist, 1; School of Dentistry, Doctor of Dental Surgery, 3. The attendance of the Graduate School was the largest in its history. Three hundred and seventeen were registered, representing 33 states and four foreign countries. Among the number were 16 vocational students under the direction of the Federal Board for Vocational Education.

TULANE BANQUETS.—On June 6 Tulane Alumni Association tendered a banquet to its members, and on June 7, Parke Davis & Co., were hosts of the medical graduating class. Interesting and instructive addresses were delivered on both occasions, being enjoyed to the fullest extent by all present.

CIVIL SERVICE EXAMINATION.—The United States Civil Service Commission announces an open competitive examination for

junior physiologist, on July 6, 1920. The salary attached is $2,000 per year and quarters for single employee, and vacancies in positions requiring similar qualifications, at this or higher or lower salaries, will be filled from this examination, unless it is found in the interest of the service to fill vacancy by reinstatement, transfer, or promotion. Applicants should at once apply for Form 1312, stating the title of the examination desired, to the Civil Service Commission, Washington, D. C., the Secretary of the United States Civil Service Board, Customhouse, in their district. Applications must be filed with the Civil Service Commission, Washington, D. C., prior to the hour of closing business on July 6, 1920.

Milk Profiteers Take Terrific Death Toll.—Profiteering in milk is responsible for the death of hundreds in Vienna. Statistics gathered by the American Red Cross show that 50,000 persons are suffering from influenza in the Austrian city, and three-fourths are unable to obtain medical attention, deprived of medicines and nourishing food. Milk is virtually unobtainable for any but the rich, who are paying as much as $10 a quart to profiteers. When American relief workers in Vienna called the attention of the city authorities to the appaling mortality the officials replied that the impoverished state of the city treasury rendered impossible any organized and effective measures to suppress profiteering.

Another Sanatorium for Tuberculous Soldiers.—According to an announcement by Surgeon General Hugh S. Cumming, the magnificent tuberculosis sanatorium operated by the Army authorities at Fort Bayard, N. Mex., has been transferred to the U. S. Public Health Service, and will be available for treating discharged, disabled soldiers. The Sanatorium will provide 1,000 additional beds for the care of tuberculous patients. The present sanatorium at Deming will be held in reserve, especially for winter use. At Fort Bayard the Public Health Service will treat only ambulatory cases in which the prognosis is favorable.

National Research Council Elects Officers.—The National Research Council, a cooperative organization of leading scientific and technical men of the country for the promotion of scientific research and the application and dissemination of scientific knowledge for the benefit of the national welfare, has elected the follow-

ing officers for the year beginning July 1, 1920: Chairman, H. A. Bumstead; First Vice-Chairman, C. D. Walcott; Second Vice-Chairman, Gano Dunn; Third Vice-Chairman, R. A. Millikan; permanent secretary, Vernon Kellogg; treasurer F. L. Ransome. The Council was organized in 1916 under the auspices of the National Academy of Sciences to mobilize the scientific resources of America for work on war problems, and reorganized in 1918 by an executive order of the President on a permanent peace basis. It has recently received from the Carnegie Corporation, an endowment of $5,000,000 part of which will be used in erecting a suitable building in Washington for the joint use of the Council and the National Academy of Sciences. Other gifts have been made to it for the carrying out of specific scientific researches under its direction.

MEETING GASTRO-ENTEROLOGICAL SOCIETY.—The annual meeting of the American Gastro-Enterological Society was held in Atlantic City, May 3 and 4, and the following officers were elected for the year 1920-21: Dr. Joseph Sailer, Philadelphia, president; Drs. Allan A. Jones, Buffalo, and James C. Johnson, Atlanta, Ga., vice-presidents; Dr. Frank Smithies, Chicago, secretary (re-elected); Dr. Horace W. Soper, St. Louis, recorder, and Dr. Clement R. Jones, Pittsburgh, treasurer.

AMERICAN SURGICAL ASSOCIATION ELECTS OFFICERS.—The forty-first annual meeting of this association was held in St. Louis, May 3 to 5 and the following officers were elected: President, Dr. John B. Roberts, Philadelphia; vice-presidents, Drs. Harvey G. Mudd, St. Louis, and James F. Mitchell, Washington, D. C.; secretary, Dr. John H. Gibbon, Philadelphia (re-elected); treasurer, Dr. Charles H. Peck, New York City, and recorder, Dr. John H. Jopson, Philadelphia (re-elected).

MEETING AMERICAN PHYSICIANS' ASSOCIATION.—The annual meeting of this association was held in Atlantic City, N. J., May 4 and 5. Election of officers resulted as follows: President, Dr. W. S. Thayer, Baltimore; vice-president, Dr. H. C. Moffitt, San Francisco; secretary, Dr. Thomas McCrae, Philadelphia; recorder, Dr. Thomas R. Boggs, Baltimore, and treasurer, Dr. Joseph A. Capps, Chicago.

NERVOUS AND MENTAL DISEASES RESEARCH ASSOCIATION FORMED.—This association was recently formed on the initiative

of the New York Neurological Society, and has been organized to promote research in neuro-psychiatric diseases. It is planned to hold annual meetings, at which only one subject will be discussed. A commission will conduct the meetings whose members will act as an investigating body. At the conclusion of the meeting the commission will prepare and publish only such material as it sees fit. Subjects will be given out from one to three years in advance of each meeting. New York City has been chosen for the first meeting, to occur late in December, 1920. The chairman of the organization committee is Dr. Walter Timme, New York City; Dr. Frederick Tilney, New York City, has been chosen chairman of the committee on arrangements for the first annual meeting.

Colleges Combine.—Maryland State College of Agriculture and the Maryland School of Medicine have been combined under the name of University of Maryland. This gives the new institution a college of arts and sciences, military school, and schools of medicine, dentistry and pharmacy. An appropriation has been made by the legislature of $42,500 each year for the medical school for the next two years, and an additional appropriation of $203,000 for building and equipment.

New Dean of Oregon University Appointed.—Dr. Richard B. Dillhunt, of Portland, Oregon, formerly assistant dean, has been appointed dean of the medical department of the University of Oregon, to succeed the late Dr. K. A. J. Mackenzie. Increased facilities for teaching and research work with construction of special hospitals have been proposed.

Meeting Mississippi State Medical Association.—The thirty-third annual meeting of this association was held in Jackson, May 11 and 12. The following officers were elected; President, Dr. John W. Barksdale, Winona; vice-presidents, Drs. Horace H. Kinney, Okolona; William A. Johns, Corinth, and Lawrence B. Hudson, Hattiesburg; secretary, Dr. Thomas M. Dye, Clarksdale (re-elected); treasurer, Dr. James M. Buchanan, Meridian.

Clinical Surgeons of Texas.—This is the name of a new medical organization recently formed in Texas, and is a branch of the American College of Surgeons. Officers selected are as follows: President, Dr. Bacon Saunders, Ft. Worth; secretary, Dr. W. B. Thorning, Houston; councilor, Dr. W. B. Russ, San Antonio.

YALE RECEIVES GIFT.—The General Education Board of New York has donated $1,000,000 to the Yale University endowment fund. The endowment is to be used in the development of the New Haven General Hospital through the medical school of the university.

HONORS FOR GENERAL GORGAS.—King George of England, recently conferred on Gen. W. C. Gorgas, the knight commandership of the Order of St. Michael and St. George.

AMERICAN PEDIATRIC SOCIETY MEETING.—The thirty-second annual meeting of this society was held in Highland Park, Ill., May 31 to June 2. Following are the officers elected: President, Dr. John Howland, Baltimore; vice-president, Dr. Charles A. Fife, Philadelphia; secretary, Dr. Howard C. Carpenter, Philadelphia; treasurer, Dr. Charles H. Dunn, Boston, and recorder and editor, Dr. Oscar M. Schloss, New York City.

FORWARD MOVEMENT OF QUEEN'S MEDICAL COLLEGE.—As a general movement forward, Queen's Medical College, Kingston, Ontario, has advanced all salaries and added six new professors to its faculty. The general hospital will be enlarged as about a million dollars are in sight for the work. It is thought now that it will not be necessary to remove to Ottawa as was contemplated a few months ago.

GENERAL MEDICAL CONGRESS.—Under the presidency of Prof. Minkowski, the thirty-second meeting of the *Deutsche Kongress fur Innere Medizin* was held in Dresden April 20 to 23. The present position of immunotherapy and chemotherapy in infectious diseases was one of the subjects discussed.

ITALIAN MEDICAL PRIZE COMPETITION.—A competition for the Humbert I prize of 3,500 lires for the best orthopedic work or invention, is announced by the Instituto Orthopedico Rizzoli, of Bologna, Italy. The competition is open to foreigners, and conditions may be learned by addressing the president of the institute. The competition closes December 31, 1920.

HOTEL DIEU STAFF ORGANIZES.—On June 15, the staff of the Hotel Dieu was formed into a permanent organization. Thirty-eight members were present, and it is planned to hold meetings monthly. Officers elected to serve for the ensuing year are: Dr.

Marion Souchon, president; Dr. Homer Dupuy, vice-president; Dr. H. W. E. Walther, secretary and Dr. L. A. Fortier, recorder.

THE COLORADO CONGRESS OF OPHTHALMOLOGY AND OTO-LARYNGOLOGY will be held in Denver, July 23 and 24, 1920.

PERSONAL.—Dr. J. George Dempsey has been appointed statistician of the State Board of Health to succeed the late Dr. Ellis.

REMOVALS.—Dr. G. McG. Stewart, from St. Francisville, La. to Clinton, La.

Dr. H. Johnston, from Wilson, La., to Reymond Building, Baton Rouge, La.

Dr. A. F. Jones from Ararat, N. C., to Cameron, N. C.

DIED.—On June 18, in this city, Dr. Henry S. Bennett, of Jonesville, La., aged 40 years.

BOOK REVIEWS AND NOTICES

All new publications sent to the JOURNAL *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* JOURNAL *to review as many of the works accepted as possible, the editors will be guided by the space available and the merit of respective publications. The acceptance of a book implies no obligation to review.*

The Medical Clinics of North America. W. B. Saunders Company. Mayo Clinics Number, November, 1919. Boston Number, January, 1920.

These two issues maintain the usual standard of excellence of the publication. The topics presented are representative of the problems actively discussed by the profession. For the most part, the easy style and conciseness of the clinics catch the attention of the reader and maintain it. There can be no doubt as to the educational merit of the case method—for such this series largely is. I. I. LEMANN.

The Narcotic Drug-Problem, by Ernest S. Bishop, M. D., F. A. C. P., 8 vo. pp. 158. The MacMillan Company, New York, 1920.

Dr. Bishop has made an earnest plea for the consideration of the drug addicts not as degraded "weak minded, deteriorated wretch, mental and moral derelicts" but as individuals suffering from a "definite physical condition, presenting constant and definite physical symptoms and signs, ... explainable by a mechanism of body protection against the action of narcotic toxins . . . . .". He insists that they take their drug not usually for sensual gratification but for the relief of actual physical suffering caused by the withdrawal or lack of the drug. Some antidotal toxic substance has become the constantly present poison, and the narcotic drug itself has become simply the antidote demanded

for its control. Many drug addicts when kept supplied with their drug are able to hide their secret and, not showing any bye-effects, are useful and respected members of society. They should not be placed in the position of the criminal and the vicious. The author's plan of treatment is first to bring his patient into the best possible physical condition both by permitting the minimal amount of drug suffcient and adequate to meet his needs and by attention to his general health, getting rid of all possible abnormalities, physical and psychical; then to conduct "as rapid a withdrawal as is compatible with my patient's reactive condition and the reactions of his disease." He hastens elimination but keeps "well away from exhausting purgation." Hyoscin and belladonna and their congeners he regards as too dangerous to be used routinely, though he admits that they are at times useful in the treatment of addiction. In general, therefore, he is opposed to the Towns (Lambert) treatment or any other routine scheme. On the other hand, his own plan is so vaguely outlined as to be little satisfying even to one who is ordinarily opposed to dogmatic, rigid plans of treating disease. There is much reiteration of the author's view point and the work could profitably have been brought into smaller compass. The message the book carries is one well deserving the serious attention of the profession and it is expressed in a clear, readable and forceful manner.

I. I. LEMANN.

The Diseases of Infants and Children, by J. P. Crozier Griffith, M. D., Ph. D. W. B. Saunders Co., Philadelphia and London, 1920.

This complete work in two volumes should be found in the library of every physician. In recent years, so many books covering the subject of Pediatrics have been published, but it remained for this author to present so varied a subject from as many view points.

All topics are covered in their entirety. The many references covering the important subjects, the simplicity of expression, the systematized distribution, are only a few of the added virtues of this splendid and painstaking work.

C. J. BLOOM.

PUBLICATIONS RECEIVED

LEA & FEBIGER, Philadelphia and New York, 1920.

Principles of Human Physiology, by Ernest H. Starling, C. M. G., F. R. S., M. D., Hon. Sc. D., F. R. C. P.

Text-Book of Dermatology, by J. Darier, M. D., authorized translation from the second French edition. Edited with notes by S. Pollitzer, M. D.

Pathogenic Microorganisms, by William H. Park, M. D., and Anna Wessels Williams, M. D., assisted by Charles Krumwiede, Jr., M. D. Seventh edition, enlarged and thoroughly revised.

A Manual of Physical Diagnosis, by Austin Flint, M. D., LL. D. Eighth edition revised by Henry C. Thacher, M. S., M. D.

A. Diabetic Manual, by Elliott P. Joslin, M. D., second edition, thoroughly revised.

A. Laboratory of Syllabus of Clinical Pathology, by Charles E. Simon, B. A., M. D.

Note:—We note that in the April number of the **New Orleans Medical and Surgical Journal** you failed to put our name as the publishers of Brown's Rules for Recovery from Pulmonary Tuberculosis. Could you not make correction in your next issue?

Very truly, LEA & FEBIGER.

F. A. DAVIS COMPANY, Philadelphia, 1919 and 1920.

Principles and Practice of Infant Feeding, by Julius H. Hess, M. D., second revised edition. (1919).

Regional Anesthesia (Victor Pauchet's Technique), by B. Sherwood-Dunn, M. D. (1920).

W. B. SAUNDERS COMPANY, Philadelphia and London, 1920.

The Surgical Clinics of Chicago, April, 1920, Volume 4, No. 2.

P. BLAKISTON'S SON & CO., Philadelphia, 1920.

Pharmaceutical Bacteriology, by Albert Schneider, M. D., Ph. D.

WM. WOOD & COMPANY, New York, 1920.

Cunningham's Manual of Practical Anatomy, revised and edited by Arthur Robinson. Seventh edition. Volume second, Thorax and Abdomen.

JOHN WILEY & SONS, Inc., New York, 1920.

Manual of Psychiatry, edited by Aaron J. Rosanoff, M. D. Fifth edition, revised and enlarged.

BAIRD-WARD PRINTING CO., Nashville, Tenn., 1920.

The Care and Feeding of Southern Babies, by Owen H. Wilson, M. D. 1920.

WASHINGTON GOVERNMENT PRINTING OFFICE, Washington, D. C., 1920.

United States Naval Bulletin.. Vol. 14, No. 2.

Military and Naval Insurance, and Military and Naval Compensation Claims as a result of the World War.. June 30, 1920.

U. S. Department of Agriculture, Service and Regulatory Announcements.. Supplements. Notices of Judgment under the food and Drugs Act. May 4, 1920.

Public Health Reports, Volume 35, Nos. 18, 19, 20, 21, 22.

THE PANAMA CANAL PRESS, Mount Hope, C. Z., 1920.

Report of the Health Department of the Panama Canal for January, February, March, 1919.

MISCELLANEOUS:

Government by Default. Address before the Association of Life Insurance Counsel, by Hon. Job E. Hedges, Gen. Counsel, Association of Life Insurance Presidents.

On the Epidemic, Acute and Subacute Non-Suppurative Inflammations of the Nervous System Prevalent in the United States in 1918-1919: Encephalitis; Encephalomylitis; Polyneuritis; and Meningo-Encephalo-Myeloneuritis. Extracted from the **American Journal of the Medical Sciences,** by Lewellys F. Barker, M. D., Ernest S. Cross, M. D. and Stewart V. Irwin, M. D.

REPRINTS.

Modern Scientific Views on the Pathologic Basis of Narcotic Drug Addiction, by Christian F. J. Laase, B. S., M. D.

MORTUARY REPORT OF NEW ORLEANS.

Computed from the Monthly Report of the Board of Health of the City of New Orleans, for May, 1920.

CAUSE.	White.	Colored.	Total.
Typhoid Fever			
Intermittent Fever (Malarial Cachexia)			
Smallpox	2	8	10
Measles			
Scarlet Fever	1		1
Whooping Cough	1	1	2
Diphtheria and Croup	1	1	2
Influenza			
Cholera Nostras			
Pyemia and Septicemia	1		1
Tuberculosis	28	38	66
Cancer	24	10	34
Rheumatism and Gout		3	3
Diabetes	2	1	3
Alcoholism	1		1
Encephalitis and Meningitis	2		2
Locomotor Ataxia	1		1
Congestion, Hemorrhage and Softening of Brain	13	7	20
Paralysis	2	2	4
Convulsions of Infancy			
Other Diseases of Infancy	7	5	12
Tetanus			
Other Nervous Diseases	1	1	2
Heart Diseases	41	20	61
Bronchitis	3	3	6
Pneumonia and Broncho-Pneumonia	17	16	33
Other Respiratory Diseases	1	1	2
Ulcer of Stomach	2	1	3
Other Diseases of the Stomach	1	2	3
Diarrhea, Dysentery and Enteritis	11	17	28
Hernia, Intestinal Obstruction	1	5	6
Cirrhosis of Liver	6	4	10
Other Diseases of the Liver	1	3	4
Simple Peritonitis			
Appendicitis	2	3	5
Bright's Disease	18	18	36
Other Genito-Urinary Diseases	9	8	17
Puerperal Diseases	3	5	8
Senile Debility	2		2
Suicide	2		2
Injuries	23	17	40
All Other Causes	27	15	36
TOTAL	251	215	466

Still-born Children—White, 17; colored, 22; total, 39.

Population of City (estimated)—White, 290,000; colored, 110,000; total, 400,000.

Death Rate per 1000 per annum for Month—White, 10.39; colored, 23.45; total, 13.98. Non-residents excluded, 11.95.

METEOROLOGIC SUMMARY (U. S. Weather Bureau).

Mean atmospheric pressure 29.96
Mean temperature 78
Total precipitation ..... 4.08 inches
Prevailing direction of wind, southeast.